2021

HHC HEART HEALTH CENTER

ASC INFORMATION PACKET

PLEASE READ INSTRUCTIONS CAREFULLY, BRING COMPLETED FORMS WITH YOU ON DAY OF PROCEDURE

GENERAL PATIENT INFORMATION
PATIENT RIGHTS AND ADVANCED DIRECTIVES
DISCLOSURE ON OWNERSHIP NOTICE
NOTICE ON PRIVACY PRACTICES

PROCEDURE INSTRUCTIONS
MEDICATION RECONCILIATION

CONSENT FOR RELEASE OF INFORMATION
FINANCIAL AGREEMENT
ASSIGNMENT OF INSURANCE BENEFITS
RELEASE OF MEDICAL RECORDS

HEART HEALTH CENTER

Notes

HEART HEALTH CENTER

GENERAL PROCEDURE INSTRUCTIONS

- **COVID TESTING:** Our surgery center is a COVID-free and safe place. To ensure this continuedsafety for all our patients and staff, you will need to complete COVID testing before your procedure if you are not vaccinated. Turn-around times for test results vary depending on the testing facility. You will need to provide us with a copy of the results.
    - COVID testing locations include Embry Women's Health, CVS, and Walgreens pharmacies
        - Please contact our office if you need assistance scheduling a COVID test onlinewith Embry, CVS, or Walgreens

- **ANTIARRHYTHMIC BEFORE YOUR ABLATION PROCEDURE:** If you are on an antiarrhythmic medication like **AMIODARONE**, **SOTALOL**, **TIKOSYN,** or **FLECAINIDE** or a similar agent, AND youare undergoing an ablation procedure, we may instruct you to stop your ANTIARRHYTHMIC medication up to 4 days before your procedure.

- **BLOOD THINNERS BEFORE YOUR SURGICAL PROCEDURE:** Please stop your **BLOOD THINNERS**for at least 24 hours. You are generally not required to stop ASPIRIN or PLAVIX. If you take **ELIQUIS**, **PRADAXA,** or **XARELTO,** STOP 24 hours before the procedure. If you are taking **WARFARIN** or **COUMADIN,** you may continue the medicine but not take it on the procedure day. The instructions to stop blood thinners vary from case to case. Please ask your physician or nurse about blood thinner directions that apply to you.
- **General Blood Thinner exceptions** include:
    - For patients having a **Coronary or Vascular procedure**, you may have been instructed to STOP your BLOOD THINNERS for **up to 5 days**. Verify with your physician ortheir medical assistant.
    - For patients having a **TEE and/or cardioversion**, do NOT stop your blood thinners.

- **OTHER MEDICATIONS:** If you are having a **pacemaker/defibrillator implant** or

a **coronary angiogram (i.e., a Left Heart Cath),** please do not take your **metformin** the morning of the procedure of 48 hours afterward.

- **NOTHING TO EAT OR DRINK AFTER MIDNIGHT (or for at least 8 hours).** You can take yourmedicines with a small sip of water.

- **SHOWERS AND SHAVING OF SURGICAL SITE:** take at least two good showers before the procedure (generally, one on the night before and one on the day of the procedure). You should use a medicated soap like HIBICLENS. You can usually get it over the counter at your local Walgreens or pharmacy. **If instructed, shave the surgical site area carefully.**
- **WHAT TO BRING:** Please bring your photo ID, insurance card, and updated medication list with you to your procedure. You may also bring your medications with you, such as inhalers or blood thinners.
- **ARRIVAL TIME:** Please arrive at least **30 minutes before** your procedure time.
    - HEART HEALTH Surgery Center: 1848 E Thomas Rd, Phoenix, AZ 85016, STE 200 (upstairs)

- **SCHEDULED PROCEDURE TIME:** Remember that your scheduled procedure time is approximate. Your actual procedure start time will vary, depending on how long it takes to perform the procedures scheduled before you. We will update you frequently and make all efforts to get you in the procedure room as fast as possible.

- **GOING HOME AFTER PROCEDURE:** Please plan to be at our facility for 3-6 hours and make sure you have a ride to take you home(if you are being administered sedation/anesthesia).

- **FURTHER INFORMATION:** If you have additional questions or want more information on thespecific procedure, please ask your physician or visit the RESOURCES page, http://azheartrhythmcenter.com.

Additional Instructions

PLEASE READ AND SIGN ALL PAPERWORK

Please bring the completed paperwork with you, and plan to stay **2-3 hours.** Sometimes patient flow may make your stay longer.

Please bring your **insurance cards, a picture ID, co-pay/deductible,** and a list of your medications, including dosage and how often you take them.

Please make sure you have someone who can take you home.
Your ride will generally need to remain at the Center while you are in the procedure roomand afterward in the recovery room. You will be ready to go home after your procedure and anesthesia recovery has finished.

We are not responsible for your lost or stolen articles. Please leave them at homeor with your driver.

As a Medicare-certified facility, we must inform you of certain information before the date of your procedure. This information is also contained in a document on our website, www.azheartrhythmcenter.com. Please click on the heading "Resources." "Online Forms" The document will be entitled *ASC Patient Information Packet.*

If you do not have Internet access, we will provide you with a paper copy of this information.

We look forward to seeing you.
If you have any questions, please call:
(602) 638-1240

HHC HEART HEALTH CENTER

1848 E. Thomas Rd, Suite 200, Phoenix, AZ 85016

If you Need to Reschedule Your Procedure

Your procedure is scheduled at Heart Health Center, and your appointment time is reserved specifically for you. It can often take weeks to schedule a procedure due to the limited availability of time in the Center.

If you do need to reschedule your procedure, please do so at least 72 hours in advance. This will allow other patients to use this time in the Center.

To cancel or reschedule a procedure, please call **(602) 638-1240**.

If your insurance changes before your procedure, please call your Physician's Office or us to ensure that your new insurance will cover your scheduled procedure.

Thank you!

HHC HEART HEALTH CENTER

HEART HEALTH CENTER

[PATIENT LABEL]

PATIENT INFORMATION SHEET

Please Print Clearly:

Last:	**First:**	**Middle:**	**Sex:**
SSN:	**Date of Birth:**	**Age:**	**Home Phone:**
Address:	**City:**	**State:**	**Zip:**
Email Address:		**Mobile Phone:**	
How do you prefer to be contacted (Mark Y/N): Home Phone: _____ Mobile Phone: _____ Email:_____			
Occupation:	Employed By:	Business Phone:	
Name of Spouse:	Employed By:	Business Phone:	
In Case of Emergency, Notify:	Relationship:	Phone:	
Name of Primary or Referring Physician:			

Primary Insurance:	**Secondary Insurance:**
Name of Insurance: _____	Name of Insurance: _____
Street Address: _____	Street Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____	Phone: _____
Subscriber: _____	Subscriber: _____
Relation to Patient: _____	Relation to Patient: _____
SSN: _____ DOB: _____	SSN: _____ DOB: _____
Policy #: _____	Policy #: _____
Group: _____	Group: _____
Effective Date: _____	Effective Date: _____

CONSENT FOR RELEASE OF TREATMENT RECORDS/ INSURANCE AUTHORIZATION

I hereby authorize the release of information to my insurance company concerning charges/treatment provided to me by the physicians of Heart Health Center. Transmittal by Fax is authorized. I hereby assign benefits to Heart Health Center. I understand that payment is due as services are provided unless I have authorized insurance billing, and I have been informed of the cost of the procedure I am having today. If, after 60 days, an insurance payment has not been received, I understand that the charges are my responsibility and payable immediately. In the event that payment is not made on this account, and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to a maximum of 50% of our understanding balance at the time the account is placed with the agency. The interest of 10% per year will be accrued on the principal balance. Should legal action also be necessary to collect the account, I/we agrees to pay attorney's fees and court incurred for collection.

Patient's Signature: X_____ **Date**: _____

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[PATIENT LABEL]

Heart Health Center
Patient Medication Reconciliation Form

Name of Medication (Please Print)	Current Dose	Frequency:	Last Dose Taken (Date):

Nurse Signature: _____Date: _____

New Medications or Dosages you should take after discharge:

Name of Medication (Please Print):	Dose:	Frequency:

Nurse Signature: _____Date: _____

1848 E. Thomas Rd, Suite 200, Phoenix, AZ 85016

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I hereby authorize **Heart Health Center** to use and disclose the health information that identifies me explicitly or reasonably to carry out my treatment, payment, and healthcare operations. While this consent is voluntary, I understand that if I refuse to signthis consent, Heart Health Center can refuse to treat me.

I have been informed that **Heart Health Center** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations. I understand that I have the right to review such a Notice before signing this consent.

I understand that I may revoke this consent at any time by notifying **Heart Health Center** in writing. Still, if I withdraw my consent, such revocation will not affect any Heart Health Center's actions before receiving my revocation.

I understand that **Heart Health Center** has reserved the right to change its privacy practices, and I can obtain such a changed Notice upon request.

I understand that I have the right to request that **Heart Health Center** restricts how my individually identifiable health information is used and disclosed to carry out treatment, payment, or health operations. I understand that **Heart Health Center** does not have to agree to such restrictions, but that once such limits are agreed to, **Heart Health Center** must adhere to such restrictions.

With whom may we share your medical/financial information:

_____

_____

X _____

Signature of patient or patient's representative

_____

Printed Name of Patient or Patient's representative

_____

Relationship to the Patient

_____

Date

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Heart Health Center

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and physicians who render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed-upon balance at the time of service.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Heart Health Center, my admitting physician, or other physicians who render service to me, The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances clue after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physicians who render service to charges not paid for within a reasonable period oftime by insurance or third-party payer. I certify that the information given about insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, or when required for submission of an insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to the date of the procedure that the physicians who perform procedures/services at Heart Health Center may have an ownership interest in Heart Health Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Heart Health Center,

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all my information reported to the Center is correct.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights before the date of the procedure. I have also received information regarding Heart Health Center policies pertaining to ADVANCE DIRECTIVES prior to the date of the procedure. Information regarding Advance Directives, along with official State documents, have been offered to me upon request.

☐Living will _____ (Location, if applicable)

☐Medical Power of Attorney: _____ (Designee, if applicable)

☐I would like to choose someone to speak on my behalf in the event that I am unable to speak for myself: _____, (Designee).

☐I would like information on Advance Directives.

☐I have none of the above and do not wish one,

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

X

_____ _____

Signature of Patient or Responsible Party Print Name

_____ _____

Relationship to Patient Date Signed

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EXPLANATION OF YOUR BILL

You are scheduled for a procedure at Heart Health Center. The total cost may be comprised of four provider fees: the Heart health Center's fee, the physician's fee, and the anesthesia fee. Each provider bills fees separately.

• **Heart Health Center's fee** covers the cost of providing the technicians, nurses, equipment, andsupplies involved in the performance of your service; co-pays, Co-Insurance, and Deductibles aredue at the time of service. If your insurance company finds you are responsible for an additional balance after processing the claim, you will be billed separately for that amount, and payment will be due within 30 days. If you have any questions regarding your bill from Heart Health center, please call their **Billing Department** at **(602) 456-2342.**

• The **Physician's Professional Service fee** is for providing the procedure, supervising, interpreting, and consulting with you and your referring physician. Your physician from **Arizona Heart Rhythm Center** will bill you separately for the physician's professional fee. If you have any questions regarding your physician's bill, please call their **Billing Department** at **(602) 456-2342, option 4.**

• The **Anesthesia fee** covers the cost of providing Propofol anesthesia for your procedure. If you have any questions regarding your bill from anesthesia, please call their **Billing Department at (480) 420-4027.**

Interpreting your insurance explanation of benefits (EOB):

- **Total Charges:** This is the total amount each provider will bill to insurance.
- **Allowed Amount:** This is the total amount expected to be paid by insurance and patient combined. (It is also called the negotiated amount or contracted amount).
- **Payable amount:** This is the amount that the primary insurance will pay.
- **Patient responsibility:** This is the difference between the allowed amount and the payable amount. This represents any deductibles and co-payments or co-insurance. If youhave secondary insurance, they may pay for all or part of the "patient responsibility," depending on your contract.

I **have read and understood the above information.**

X

_____ _____

Patient Signature Date

_____

Print Name

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Patient Health Information
Under federal law, your patient health information is protected and confidential Patient health informationincludes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and, if so, is subject to electronic disclosure.

How We Use & Disclose Your Patient Healthinformation
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. They may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and tofamily members who are helping with your care.
Pavement: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services, and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures
Following a procedure, we **will** disclose your discharge instructions and information related to your care to the individual who is driving you homefrom the Center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend, or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures
We may be required or permitted to use or disclosethe information even without your permission as described below:
Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information forapproved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may disclose information toassist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request, or courtorder.
Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on ourpremises.
Deaths: We may disclose information regardingdeaths to coroners, medical examiners, funeral directors, and organ donation agencies,
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safetyor the health and safely of the public or another person.
Military Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers' compensationor similar programs providing benefits for work-related injuries or illness.
Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail, or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If youchoose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we **will** not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information unless you have signed an authorization.

Individual Rights
You have the following rights regardingyour health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.
□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by request and when the usesor disclosures are not required by law.
□ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
□ In most cases, you have the right to look at orget a copy of your health information. There may be a small charge for copies.
□You have the right to request that we amendyour information.
□ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operationsand except for other exceptions.
□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty
We are required by law to protect and maintainthe privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information aboutom privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the **U.S.** Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Tammy Evans, RN and Director of Nursing at
(602) 638-1240

I, _____
hereby acknowledge receipt of the Notice of Privacy Practices given to me:

Signed: X_____Date:_____

If not signed, reason why acknowledgement was If not obtained:

_____
_____

Staff Witness Seeking Acknowledgement:

Name: _____ Date: _____

HHC HEART HEALTH CENTER

1858 E Thomas Road, Suite 200
Phoenix, AZ 85016

Version 3.0
Date: August 1st, 2017

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Patient's Rights and Notification of Physician Ownership

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF YOUR PROCEDURE

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL AND TO ACTIVELY PARTICIPATE IN AND MAKE INFORMED DECISIONS REGARDING THEIR CARE. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING PATIENT RIGHTS AND RESPONSIBILITIES, WHICH ARE COMMUNICATED TO EACH PATIENT OR THE PATIENT'S REPRESENTATIVE/SURROGATE BEFORE THE PROCEDURE

PATIENT RIGHTS:

The patient has the right to:

- To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment,
- To receive considerate, respectful, and dignified care.
- To be provided privacy and security during the delivery of patient care service.
- To receive information from their physician about their illness, their course of treatment, and prospects for recovery in terms that they can understand.
- To receive as much information about any proposed treatment or procedures as they
- Reasonable continuity of care and to know in advance the time and location of the appointment, as well as the physician providing the care, may need to give informed consent before the start of any procedure or treatment.
- When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- To make decisions regarding the health care that the physician recommends. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health. The reason shall be reported to the physician and documented in the medical record.
- To be free from mental and physical abuse or exploitation during patient care,
- Full consideration of privacy concerning their medical care. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly.
- Confidential treatment of all communications and records about their care and their stay in the facility. Their written permission shall be obtained before their medical records can be made available to anyone not directly concerned with their care. The facility has established policies to govern access and duplication of patient records,
- To have care delivered in a safe environment, free from all forms of abuse, neglect, harassment, or reprisal. Be informed by their physician or a delegate of their physician of the continuing health care requirements following their discharge from the facility. To know the identity and professional status of individuals providing services to them and the name of the physician who is primarily responsible for the coordination of their care
- To know which facility rules and policies apply to their conduct while a patient.
- To have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patients' rights.
- To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's care, l11c patient1s written consent for participation in research shall be obtained and retained in their patient record.
- To examine and receive an explanation of their bill regardless of the source of payment. To appropriate assessment and management of pain
- To be advised if the physician providing care has a financial interest in the surgery center. To be informed of your right to change providers if other qualified providers are available

PATIENT RESPONSIBILITIES

- To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
- To follow the treatment plan prescribed by their provider, including pre-operative and discharge instructions,
- To provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider.
- To inform their provider about any living will, medical power of attorney, or other advance healthcare directive in effect.
- To accept personal financial responsibility for any charges not covered by their insurance. To be respectful of healthcare personnel and staff as well as other patients.

IF YOU NEED AN INTERPRETER:

If you need an interpreter, please let us know, and one will be provided for you. If you have someone who can translate confidential, medical, and financial information for you, please make arrangements to have them accompany you on the day of your procedure.

RIGHTS AND RESPECT FOR PROPERTY AND PERSON

The patient has the right to:

- Exercise their rights without being subjected to discrimination or reprisal.
- Voice a grievance regarding treatment or care chat is, or fails to be, furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Confidentiality of personal medical information.

PRIVACY AND SAFETY

The patient has the right to:

- Personal privacy
- Receive care in a safe setting
- Be free from all forms of abuse or harassment

ADVANCE DIRECTIVES

An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. AZ STATE laws regarding Advanced Directives are found in Arizona Statute Title 36-3201 through 36-3210. Arizona statute defines a health care directive is a document drafted in compliance with the statute " to deal with a person's future health care decisions." All adults have the fundamental right to control their medical care.

Arizona law recognizes three distinct types of documents that can be executed in advance to provide a mechanism for healthcare decision malting when a patient is no longer able to make the decisions directly. These documents are the Health Care Powers of Attorney, Living Wills, and Pre-hospital Medical Care Directives; you have the right to informed decision making regarding your care, including information regarding Advance Directives and this facility's policy on Advance Directives; applicable state forms will also be provided upon request. A member of our

Staff will be discussing Advance Directives with the patient (and/ or patient's representative or surrogate) prior to the procedure being performed.

Heart Health Center respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end-of-life decisions. Therefore, it is the policy of this Center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the Center, the personnel at the Center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made. If the patient has Advance Directives that have been provided to the Center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and their physician to determine the appropriate course of action to be taken regarding the patient's care.

COMPLAINTS/GRIEVANCES:

If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to Center management for resolution. You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken, 1hc following are the names and/or agencies you may contact:

CENTER DIRECTOR Heart Health Center: Tammy Evans, RN, Director of Nursing. Phone: (602) 638-1240 Address: 1848 E Thomas Rd, Phoenix, AZ 85016, STE 200

STATE AGENCY Arizona Department of Health Services 150 N. 18th Ave, Suite 450, Phoenix, AZ 85007 Phone: 602.364.3030 www.azdhs.gov

MEDICARE OMBUDSMAN Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman. Medicare Ombudsman Web site: http://www.medicare.gov/claims-and-appeals/medicare-rights/ get-help/ ombudsman.html Medicare: www.medicare.gov or call 1-800-MEDICARE (I-800-633-4227) Office of the Inspector General: http://oig.hhs.gov

FINANCIAL INTEREST AND OWNERSHIP: The Center is owned, in part, by the physicians. The physician(s) who referred you to this Center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure per federal regulations

THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER: Vijay Swarup, MD

Signature of Patient or Patient Legal Representative: X_____

Date: _____

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Patient Notes